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Editorials

Public–private partnerships in public health research: does it work and if yes, how?

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Private investments in research are a hot topic in the European Union (EU). Interest has increased due to the targets set in Barcelona 2002 to implement the EU 2000 Lisbon treaty, and were recently renewed.¹ The targets concern an overall investment in research and development (R&D) of 3% of their Gross Domestic Product (GDP); two-thirds of this should be private investments. In 2000, the EU countries spent only 1.82% of their GDP on R&D, with only a slight majority coming from private investments. By setting the targets, the EU expected to reinforce the competitiveness of its economy compared to e.g. the USA and Japan who indeed invested about 3% of their GDP in R&D. Recent figures have not been impressive, with an average total investment in R&D of EU countries being 1.9% of their GDP in 2010. However, the EU continues to aim at 3% in its new plan Europe 2020.¹

Public–private partnerships (PPP) are a way to realize such an increase in R&D investments, with the joint financing and performance of projects by the public and private sector.² Behind lies the idea that the private sector knows the market and the appropriate ways to invest and make profits out of investments, and that government has insight in and represents societal needs.

There is evidence of both pros and cons of PPP. To jump to the conclusion: PPP with for-profit partners may work in health research if profits on investment can be made at least theoretically. If not, then do not expect them to work, except for not-for-profit private partners. In all cases, PPP require full transparency regarding conflicts of interest and independence of research.

Prerequisites for PPP: potential profits and societal needs

Companies basically aim at profits on investments; even though other aims like transparency and sustainability are at stake as well. For companies, R&D activities in PPP should yield products that allow for a feasible profit scheme. Pharmaceutical R&D can for instance lead to profits by the mechanism of patenting. Similar mechanisms apply for diagnostic devices, (home)care technology, communication tools, etc.

Government represents the societal needs in PPP. Regarding health research, these in particular concern the promotion and protection of public health, but other societal needs may prevail too, like economic growth and sustainability.¹ Public health needs that can be translated to PPP are e.g. the development of priority medicines, vaccines and screening technologies. Regarding these topics, PPP may provide a good framework for R&D: patenting provides a potential means for companies to make profits, and public needs are apparent. However, for other public health needs, PPP with for-profit companies are unlikely to lead to a successful project. This for example applies for behavioural interventions aiming at reduction of obesity or of childhood behavioural problems. Regarding these topics, a profitable scheme is not available: patenting is unlikely, and it is difficult to set a monopoly on new evidence as obtained.

The lack of a usable for-profit scheme in many public health interventions may not always set a blockade against any PPP. First, not the entire private sector is for-profit: many trusts and other not-for-profit organizations also finance health research and may participate in PPP. Moreover, PPP may also yield effects for the general public relations and branding of companies that are restricted to those companies, even though not patentable. In these instances, many of the above remarks on the feasibility of PPP in public health do not apply.

Viability of PPP in public health research

The above examples show that PPP can be a means to support R&D in public health under specific conditions. It is then up to the public partners and the researchers involved to maintain a reasonable balance between private investments and private profits. Equally important is it for researchers to keep sufficient independence. Regarding pharmaceutical R&D there is an extensive database on the risks for researchers of becoming too dependent on private financing,³ and this equally applies to any PPP construction.

Some other risks of particular relevance to public health should be acknowledged: the first is ‘crowding out’. PPP may be so attractive for researchers that many of them focus on the topics entered by PPP that are inherently market-driven. That may lead to a lack of work force to address challenges that address societal needs that can not be translated in profitable business.² Second, PPP in any sector, inside or outside the health sector, may lead to products and developments that yield potential risks for public health, or at least raise public concerns. A typical example of this is the possible health threats of genetically modified crops. Public responses to such suspected threats require monitoring activities, which typically will be paid by public funds that might have been better needed for other investments.

The use of PPP in public health requires innovative solutions. An example of this is the branding of behavioural interventions by using a specific label and a rigid quality assurance system, and then asking remuneration for their use. This may enable to invest in an R&D trajectory, like has occurred for the Triple P family of parenting interventions (www1.triplep.net).⁴ Moreover, monitoring of the risks for public health could be a compulsory part of any PPP. And finally, both journals and researchers should aim at maximum transparency.

In short: PPP may provide additional means for public health research, even in the current economic crisis. However, the balance of gains and losses due to PPP is certainly not clear-cut positive for public health.

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Social determinants of health behaviours and social change

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There is wealth of literature on social determinants of health. The mechanisms through which social determinants influence health and health inequities are multiple. Many agree that health behaviours are in key position. In populations with marked social characterization of health behaviours, smoking, alcohol use, food habits and physical activity count for much of mortality differences between socioeconomic groups.¹ Although there is a lot of cross sectional data, there is relatively little research how social changes in a population are reflected in health behaviours within the same population and its subgroups.

Health behaviours are relatively stable; people follow—under social, economic and cultural constraints—behavioural patterns adapted in childhood and youth. However, the many intervention and monitoring studies show that population-wide behavioural changes are possible.^{2,3} But what can be learned about change and stability of health behaviours when time trends and socio-demographic differences are compared in different countries? A relevant report was recently published on health behaviours in North-Eastern Europe, in Estonia, Finland, Latvia and Lithuania in 1998–2008. This Finbalt Health Monitor report gives interesting lessons on the dynamics of social determinants of health behaviours.⁴

During the last decade Finland and the Baltic countries have gone through economic growth, increase in material living standard and stronger identification with Western European economies. However, the social changes and economic growth started much earlier in Finland, while the Baltic countries came out from the communist period only in early 1990's. Finland joined the European Union 10 years earlier than the Baltic countries. During the period of the study, 1998–2008, Finland started generally from a healthier situation and in the follow-up positive, although not dramatic changes took place, while changes in health behaviour in the Baltic countries were more pronounced.

The examples show how men in Finland smoke less than men in Estonia, Latvia or Lithuania, but smoking has decreased more rapidly in the Baltic countries than in Finland. Ten years ago, eating habits in Finland were healthier than in the Baltic countries, but since then, the Baltic countries have begun to catch up, especially with increased consumption of vegetables. In Finland risky traffic behaviours were less common than in the Baltic countries but remarkable increase in reflector and seat belt use took place in Latvia and Estonia. As a consequence, the national differences in risky traffic behaviours either disappeared or diminished.

The positive changes in the Baltic countries reflect broad social change in the health determinants, but many were due to legislative

actions and health promotion programmes in support of policy reforms. They demonstrate how policy interventions can affect health behaviour.

Socio-demographic differences in health behaviours seemed to be persistent and similar in the four countries. For example, women tend to eat vegetables more frequently and use vegetable oils, while men eat more meat products. People with higher educational level have consistently healthier food habits than those with lower educational level. Alcohol consumption has increased more among the lower educational groups. People with a low education level still smoke more and are more often exposed to tobacco smoke than those with a higher education level.

Social, economic and political changes in a nation are reflected in health behaviour of the populations. Faster structural changes lead to faster changes in health behaviour, and these changes can be either beneficial or harmful in terms of public health. Gender and socio-economic differences in health behaviours on the other hand seem to be surprisingly persistent even during political and economic turmoil.

This experience underlines the importance of national and international health monitoring recommended by the WHO report on Social Determinants of Health. Monitoring systems are essential for knowing the magnitude of the public health problems, understanding who are most affected and whether the situation is improving or deteriorating over time.⁵ Such monitoring should, indeed, include health behaviours and their social determinants.

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